3 Audiology Service Guidelines Contents

3.1 Audiology Services Policy

3.1.1 Introduction

This section covers all Medicaid services provided by hearing aid and audiology service providers as deemed appropriate by IDHW. It addresses the following:

- Claims payment
- Prior authorization
- Electronic and paper claims billing

3.1.2 Payment

Medicaid reimburses hearing aid and audiology services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

3.1.3 Client Eligibility

All Medicaid clients are eligible for audiological function testing unless they are participating in a restricted program.

Clients enrolled in the following restricted programs are not eligible for audiology services:

- PW (Pregnant Women)
- Presumptive Eligibility (PE)
- Ineligible aliens
- QMB (Qualified Medicare Beneficiary)

3.1.3.1 Healthy Connections

Check eligibility to see if the client is enrolled in Healthy Connections, Idaho's Medicaid care management program. If a client is enrolled, there are guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services. Refer to **Section 1.5** for the Healthy Connections guidelines.

3.1.4 Audiometric Testing

All audiometric testing must be physician ordered. Testing payment is limited to once each calendar year (January to December). Audiometric testing by certified audiologists and/or licensed physicians does not require prior authorization. The comprehensive audiometric exam is over and above basic audiometry and must be ordered in writing by a physician prior to performing the testing.

Audiometric testing, CPT codes 92551-92597, as described in the *Audiologic Function Tests With Medical Diagnostic Evaluation* subsection of the *Physician's Current Procedural Terminology* (CPT), is reimbursable for audiology services. Idaho Medicaid uses the most current CPT version available.

The audiometric test implies the use of calibrated electronic equipment. Other hearing tests, such as whispered voice or tuning fork, are considered

part of the general otorhinolaryngologic services and are not reported separately. All services include testing of both ears.

3.1.5 Visits

Only one charge may be made for each visit. Two hearing aid checks are allowed after the exam and selection of the hearing aid. A hearing check is not allowed on the same day as an exam or selection of the aid.

These visits are intended as a mechanism for the provider to check the hearing aid after the initial issuance. It is understood the hearing aid will be checked and be in proper functioning order when it is issued.

3.1.6 Hearing Aid Purchase

One hearing aid (monaural) per client is covered by Medicaid for adult clients 21 years of age and older.

Medicaid considers purchases of medically necessary, binaural hearing aids only for children under age 21, in cases where it is documented that, without a binaural hearing aid, the child's ability to learn would be severely restricted.

The following components are separately billable from the hearing aid:

- Ear mold
- Exam and selection
- Batteries

3.1.7 Hearing Aid Warranty and Insurance

In most cases, the hearing aid comes from the manufacturer with a one-year warranty. Medicaid requires a second-year of warranty or insurance be provided. The cost of warranty or insurance must be billed separately from the hearing aid using procedure code V5299. In some cases, the warranty or insurance cost has been added into the hearing aid price when it comes from the manufacturer. In these cases, the vendor must contact the manufacturer to determine the warranty or insurance cost and bill that cost using procedure code V5299.

3.1.8 Hearing Aid Follow-Up

The following services may be covered in addition to the purchase of the hearing aid:

- Additional ear molds that are purchased after the initial six months to one-year period may be billed for clients age 21 and under, if medically necessary.
- Four batteries may be purchased each month. Medicaid reimburses this cost up to the Medicaid maximum allowable amount for HCPCS code V5266. One unit = one battery.
- Follow-up hearing aid testing and repairs resulting from normal use may be allowed after the second year. Hearing aid testing and repairs during the first two years after purchase are included as part of the initial hearing aid purchase.
- Refitting of an adult hearing aid or additional ear molds are allowed once every 48 months.
- Lost, misplaced, stolen, or destroyed hearing aids are the responsibility of the client. Medicaid will not pay for hearing aid repairs as a result of neglect, abuse, or misuse.

3.1.9 Payment Procedures

Payment for hearing aids is determined by Medicaid. Currently, reimbursement is invoice plus 10%.

3.1.10 Physician Orders

The vendor must keep the following documentation in its files for a period of five years:

Physician's signed and dated order that includes:

- The client's diagnosis
- The results of the basis comprehensive audiometry exam
- Brand name, model, and type needed, including any options or accessories

3.1.11 Program Abuse

Medical equipment items, including hearing aids, used by or provided to an individual other than the client for whom the items were billed are prohibited. Violators are subject to strictly enforced penalties for program fraud and abuse.

Medicaid has no obligation to repair or replace any item or supply that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the item.

3.1.12 Place of Service Codes

Enter the appropriate numeric code in the place of service field on the CMS 1500 claim form or in the appropriate field when billing electronically.

11 — Office
12 — Patient's Home
21 — Inpatient Hospital
22 — Outpatient hospital
32 — Nursing facility
71 — State or local public health clinic
72 — Rural health clinic

3.1.13 Prior Authorization Requests

Approved prior authorizations are valid only for the period between the start date and stop dates. Prior authorization numbers must be included on the claim or the authorized service will be denied.

See **Section 2.3.2** for more information on billing services that require prior authorization.

For Healthy Connections clients, prior authorization will be denied if the requesting provider is not the primary care provider or a referral has not been obtained.

Requests for hearing aids for children beyond one per lifetime must be sent to the Durable Medical Equipment (DME) unit for prior authorization (PA).

Requests must include the following information:

- A completed "Idaho Medicaid DME/Supplies Request Form"
- A copy of the audiometric test results
- Make/model of the hearing aid, including any option or accessories
- Justification for the options or accessories

- Physician prescription

Attach the invoice or quote to the PA request form for consideration. The authorized reimbursement will be entered on the PA approval letter.

The Idaho Medicaid DME/Supplies Request Form can be found in the Forms Appendix. Use it to make copies as needed.

Send completed prior authorization request form to:

Bureau of Medical Care
Attn: DME
P.O. Box 83720
Boise, ID 83720-0036

Toll free: (866) 205-7403
FAX: (800) 352-6044

3.2 Claim Billing

3.2.1 Which Claim Form to Use

All claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

- To submit electronic claims, use the HIPAA-compliant 837 transaction.
- To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.2.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.2.2.1 Guidelines for Electronic Claims

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

See **Section 2** for more information on electronic billing.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring provider's Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's Healthy Connections referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.2.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2005 is entered as 07/04/2005

3.2.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.2.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.2.3.3 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

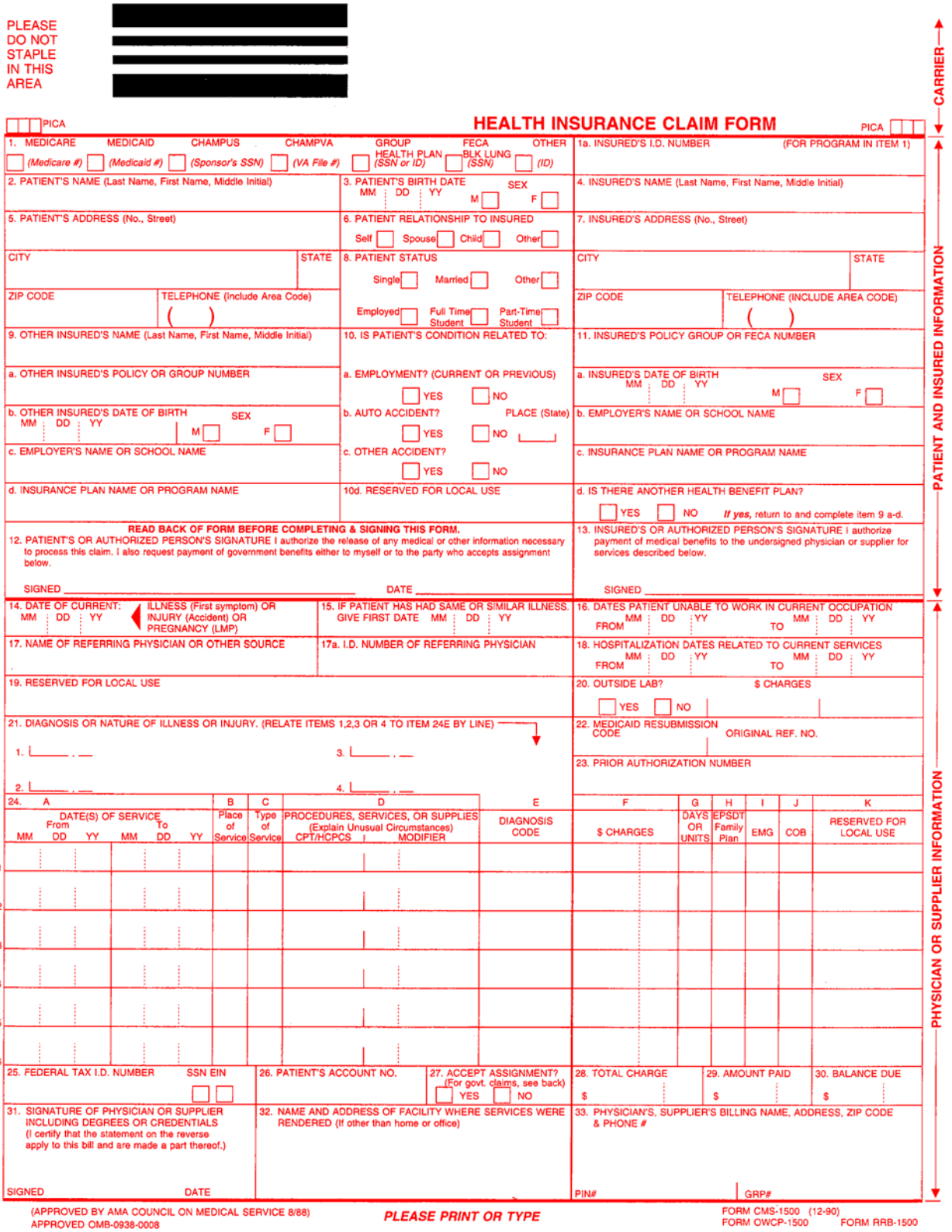
The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Insured's ID Number	Required	Enter the seven-digit client ID number exactly as it appears on the plastic client ID card.
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the date of birth and sex.

Field	Field Name	Use	Directions
9c	Employer's Name or School Name	Required if applicable	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required if applicable	If applicable, Enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	CPT/HCPCS	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.

Field	Field Name	Use	Directions
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT Family Plan	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance payment including Medicare. Attach documentation from an insurance company showing payment or denial to the claim including the explanation for the denial reason.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature of Physician or Supplier Including Degrees or Credentials	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Physician's, Supplier's Billing Name, Address, Zip Code and Phone #	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	Pin #, Group #	Required	Enter your nine-digit Medicaid provider number.

3.2.3.4 Sample Paper Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500